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PREPARING AND UTILIZING OLDER VOLUNTEERS TO PROVIDE IN-SERVICE GERONTOLOGY TRAINING

FINAL REPORT

Jon Hendricks, PhD
Principal Investigator
Department of Sociology
University of Kentucky

Linda Brasfield, MA
Co-Investigator
Multidisciplinary Center on Aging
University of Kentucky

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Report prepared by University of Kentucky Research Foundation, Department of Sociology, Center for Developmental Change and Council on Aging, 1986.

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Jon Hendricks
Principal Investigator

Linda C. Brasfield
Co-Investigator

Thomas R. Ford
Administrative Coordinator

James G. Hougland
Project Evaluator

Howard B. Turner
Research Associate

Phyllis Hanna
Administative Assistant

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I

TABLE OF CONTENTS

	Page Number
PROJECT ABSTRACT	2
POLICY/PROGRAM IMPLICATIONS	3
DISSEMINATION AND UTILIZATION	5
EXECUTIVE SUMMARY	7
FINAL REPORT: PREPARING AND UTILIZING OLDER VOLUNTEERS TO PROVIDE IN-SERVICE GERONTOLOGY TRAINING	11
INTRODUCTION	11
NEED FOR A GERONTOLOGY EXTENSION PROGRAM	13
OPERATING METHODOLOGY	15
Phase I: Course Preparation and Selection of Volunteers	15
Phase II: Volunteer Training and Workshop Scheduling	18
Phase III: Program Evaluation	
EVALUATION OF THE PROJECT	25
Training Received by Volunteers	25
Workshops Delivered by Volunteers	32
The Impact of Workshops	38
The Impact on Organizations and Communities	38
The Impact on Volunteers	40

		Page Number
CONCLUSION AND RECOMMENDATIONS		54
REFERENCES		57
APPENDICES		59
Appendix A:	Newspaper Feature Stories	60
Appendix B:	Final News Release	62
Appendix C:	Informational Announcement	65
Appendix D:	Mock Contract	70
Appendix E:	Certificate of Completion	71
Appendix F:	Map of Distribution of Project Effort	72
Appendix G:	Evaluation Form for Volunteer Presentations	73
Appendix H:	Item Included in Scales	75
	Facts on Aging	
	Self Esteem	
	Morale	
	Lonely Dissatisfaction	
	Social Alienation	
	Perceptions of Health	
	Current Health	
	Prior Health	

LIST OF TABLES

		Page Number
Table 1:	Volunteers' Evaluations of Instruction	27
Table 2:	Results of Quizzes Administered to Volunteers	31
Table 3:	Assessment of Volunteer Training (number of Respondents)	34
Table 4:	Mean Evaluation Scores for Five Priority Areas	36
Table 5:	Volunteers' Evaluations of Project Components	43
Table 6:	Attitudes of Volunteers	48
Table 7:	Predictors of Volunteers' Attitudes	50

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PROJECT ABSTRACT

In a period of rapidly growing numbers of elderly and a cutback in the level of funding available to meet their needs, community agency personnel providing services to the aged are often unable to remain abreast of new developments in their fields. To help alleviate this problem, an innovative demonstration project trained a group of retired volunteers to deliver in-service training at agency sites around the state of Kentucky.

Forty individuals completed all phases of the training process and functioned for a period of six months as in-service trainers for those who provide direct services to older persons. A three-pronged evaluation of their activities suggests that they can and do learn new material; do experience an enhanced sense of self-worth and do deliver training themselves which is perceived to be both valuable and credible by agency and program supervisory personnel. Training took place in the following priority areas, and was in turn delivered in a series of 147 short-term refresher courses (1) home health care and nursing, (2) consumer economics, (3) drugs and medication practices, (4) coping skills and adaptation, and (5) nutrition and food preparation.

POLICY/PROGRAM IMPLICATIONS

The Gerontology Extension Program (GEP) herein described provides substantial evidence that a group of retired professionals are capable of learning new information in a structured classroom situation. It further suggests that these individuals are then able to communicate their recently acquired information to those persons charged with direct service responsibilities. The in-service workshops run by the retired volunteers proved themselves to be a viable mechanism for updating the skills and knowledge base of service workers dealing with an elderly population.

One obvious policy implication of the findings reported here is that volunteers are invaluable resources if we are to improve the type and quality of services provided. The extent of the older volunteers commitment to this project convinced project staff that they constitute a major but untapped resource which could be utilized by the aging services networks in Kentucky or in any other state. We have every reason to believe that many retired persons want to offer their skills and experience to their communities provided they are given opportunities to engage in meaningful and socially respected activities.

The public service sector of local, regional and federal governments might profitably use the skills and knowledge such a population possesses to enhance their abilities to meet the goals set

forth in their own mission statements for older persons.

Obviously caution must also be exercised so that efforts to improve services delivered do not take place at the expense of the retired volunteer. Using their services to replace other trainers merely to save funds would not be in the long run interests of the target population. As project staff observed the volunteer trainers in action, we could easily envision how others might see them merely as an avenue for saving money: their enthusiasm was often so great that they themselves created an atmosphere were advantages might possibly be taken.

DISSEMINATION AND UTILIZATION

Information concerning the Gerontology Extension Program has and will be dissemination in various ways to different audiences. Within the state of Kentucky project information was distributed widely, partly because of the many recruiting announcements used to secure volunteers and to advertise the availability of training opportunities. In addition, stories about the project were prepared and released to all state newspapers by the University of Kentucky Information Services. A series of special "hometown stories" primarily of local interest were also prepared and sent to the local newspapers of each of the participating volunteers. Twice during the course of the project feature stories appeared in The Courier-Journal (see Appendix A), the major newspaper in the state and indeed the region with an estimated circulation of over 250,000. The second of these detailed the attempts to secure continuation funding for the Gerontology Extension Program. A final wrap-up news release was also prepared by the university Information Services (see Appendix B) and released to state media as well as distributed to editors of professional, state and regional public service agency newsletters.

Several members of the project staff have also made professional presentations at national conventions of age-related organizations. To date there have been at least six such professional-level presentations with more scheduled in the fall of 1986. Key project staff have also made presentations to diverse state-

wide groups of professionals working with the elderly. These have included both Directors of State Area Agencies on Aging and the State Advisory Committee for the Department of Aging Services.

Additional analyses are currently in progress and it is anticipated that a number of professional papers will be prepared and submitted to appropriate aging journals. Among the latter we anticipate submitting to a selection of the following: The Gerontologist, The Journal of Volunteer Action Research, Gerontology and Geriatrics Education, Journal of Gerontologic Social Work, The Journal of Applied Gerontology.

EXECUTIVE SUMMARY

The Gerontology Extension Project at the University of Kentucky was designed to be a demonstration program utilizing the communication skills and life experiences of retired professionals as a means to provide nominal cost in-service training to public, private and voluntary agencies providing direct services to an older clientele. In response to rapid growth in the need for aging services developed in accord with the Older Americans Act, and to local demands for high quality staff, three administrative units at the University of Kentucky cooperated in developing this unique and innovative program under the general direction of Jon Hendricks, Ph.D., Professor of Sociology, and Linda C. Brasfield, M.A., Associate Director of the Multidisciplinary Center of Gerontology, and Director, Council on Aging.

The specific goals of the project were:

> To disseminate existing knowledge to public and private service agency personnel;
>
> To improve the morale and self-concept of a group of retired professionals;
>
> To establish a much needed communication link between university faculty knowledgeable in the field of gerontology, and agencies charged with delivering services to the elderly.

To accomplish these global goals the tasks were broken into a series of sub-stages revolving around:

> The recruitment of a suitable group of 26 retired volunteers--(At a later stage a group of alternates was also selected to anticipate attrition.);

The training of these individuals in a relatively short period (28 contact hours) in one of five priority areas to an extent that they would be able to make informed and credible presentations to agency and program staff;

The evaluation of all phases of the project.

The recruitment phase was handled through a series of news releases to local newspapers, professional newsletters, groups of organized retirees and via the University of Kentucky Cooperative Extension Service which maintains agents in each of the state's 120 counties. Group interviews led to a team-based selection procedure with invitations issued to a collection of regular--(those receiving a modest honorarium)--and a small number of alternate--(reimbursed for expenses only)--volunteers. The availability of the no-charge training was made known and disseminated through a series of information brochures widely distributed across the state.

The actual training took place on the main campus of the University of Kentucky in a series of Saturday sessions taught by regular university faculty who were knowledgeable in the field of aging. In conjunction with the Training Officer of the State Division of Aging Services, five priority areas were selected based on the most recent needs assessment survey conducted by the Kentucky State Division of Aging Services. Once the areas were identified and defined, a sequence of course outlines and critiques took place in advance of the beginning of the training sessions. The five priority areas were labeled: "Coping Skills and

Adaptation"; "Home Health and Nursing"; "Nutrition and Food Preparation"; "Drugs and Medication Practices"; and "Consumer Economics".

A central office was established for purposes of receiving workshop inquiries, scheduling, and volunteer coordination. The Administrative Assistant on the project supervised the actual operation of this facility, and the duties were handled by the project secretary. Over the course of this demonstration project, th wo individuals developed close ties with both agency staff and the older volunteers, and played a key role in day to day operations. In the six month period during which on-site in-service workshops were offered, a total of 147 presentations were made in 42 separate cities or counties, at 34 different sites for a total of 59 independent agencies.

An independent evaluation team comprised of the project evaluator and the research associate was directly responsible for all components of the determination of the project's strength and weaknesses. Initial "pre-test" assessments of the older volunteer's knowledge of aging facts and information, their life-satisfaction and self-esteem, and specific components of morale based on existing literature were collected prior to the beginning of any formal project activities. Similar measures were again employed in each of two "post tests". The first of these was administered at the end of the formal training, and the second near the end of the six months of field presentations. In addi-

tion, quality of training received and of presentations made at the on-site in-service workshops was evaluated both formally and informally by means of instruments distributed to agency supervisory personnel, and informal observations conducted by the Principal Investigator, Co-Investigator, Evaluator or the Research Associate. The results were encouraging in all cases. There are, however, areas where subsequent projects of this type should anticipate making changes. For example, the informational and knowledge evaluation suggest more sharply focused training and performance practice might well improve the volunteers' performance. It should also be noted that, due to the socio-economic and life circumstances of the older volunteers, a "ceiling effect" was observed in terms of improvements possible on the well-being measures. Even with these caveats, the program was judged an unqualified success.

Efforts on the part of the Gerontology Extension Project staff to obtain continuation support from state agencies, private funding sources and retirement groups has not met with success as of this time. Local requests for follow-up in-service training were referred to the closest available volunteer training in the area from which inquiries were received. In all cases and without exception, the older volunteers expressed an interest in continuing with or without immediate financial support. They do indeed constitute an invaluable and untapped resource for up-grading the quality of services delivered across the state of Kentucky.

FINAL REPORT

PREPARING AND UTILIZING OLDER VOLUNTEERS TO PROVIDE IN-SERVICE GERONTOLOGY TRAINING

INTRODUCTION

The express purpose of this Gerontology Extension Project (GEP) was to up-grade the background knowledge and skills of service providers working directly with the elderly population of the State of Kentucky. Three trends prompted the formulation of this unique educational experiment: the development of a Gerontology Extension Program. First, the ever increasing need to up-grade the background knowledge and skills of those who provide direct services to an elderly clientele. Second, colleges and universities are presently facing declining enrollments and must broaden their appeal to remain viable educational opportunities. This is occurring on the heels of a period in which considerable faculty expertise has been nurtured in the area of aging. Third, retiring professionals are frequently deprived of opportunities to exercise the skills they have acquired over a lifetime of professional involvements.

The provision of badly needed in-service training is oftentimes precluded not only by severely restricted budgets but also by a shortage of qualified personnel prepared to offer updated training to service delivery staff. Accordingly, this project set out to provide such services at a relatively low cost. At the

same time it sought to provide a sense of purpose and utility to a small group of retired professionals who were able to add to their existing knowledge base and skills a new layer of information and activites whose social value is widely recognized.

To assist in the operationalization of these goals the task of developing a Gerontology Extension Program was broken into the following components:

Goal 1: Disseminate existing knowledge focusing on various needs of the elderly to community service agencies, both public and private, via means of a group of retired professional volunteers.

Objective 1: Train a group of retired professionals in one of five priority areas.

Objective 2: Provide a demonstration of new knowledge frontiers to human services agency personnel by teams of retired professional in-service trainers.

Objective 3: Facilitate improvement of service delivery through an upgrading of knowledge and skills of agency staff.

Goal 2: Improve the morale and self-concept of retired professionals by providing a valued and credible function of helping to improve the quality of service delivered to the elderly in general.

Objective 1: Utilize a group of retired professionals to assess whether the provision of training and new roles is of value in maintaining a sense of purpose in the years following retirement.

Goal 3: Establish a crucial communication link between key centers of gerontological knowledge, particularly institutions of higher education, and agencies charged with the application of such knowledge in meeting the needs of the elderly.

Objective 1: Utilize faculty expertise developed under the aegis of previously held AoA training awards for present training.

Objective 2: Involve university faculty in the design of workshop style in-service training courses to be delivered by the retired professionals to the agency staff.

Each goal and its objectives were evaluated by an on-going evaluation process conducted by an semi-independent evaluation team as described below. The project's success is thought to be a means of encouraging the utilization of retired volunteers in other ways to aid in the improvement of the effectiveness of overloaded service delivery systems. Also, this successful demonstration of an innovative approach to linking university-based gerontology centers with service providers should be attractive to State and service agencies across the country. It is hoped that it will also suggest alternatives to federally supported training as the only mechanism for reaching beyond the distinction between academic and applied knowledge.

NEED FOR A GERONTOLOGY EXTENSION PROGRAM

The nationwide growth in the number of elderly persons is placing an ever increasing demand on human services agencies. With greater and greater service loads, agency personnel are finding it difficult to retain state-of-the-art knowledge needed to deliver quality services. At the same time, the extensive gerontology training centers developed in the later 1970s in response to the burgeoning number of elderly and to rising student interest in

gerontology have not been as effective as they might be due to lessened student demand and a lack of coordination with service delivery networks. As a consequence, few of these centers and programs are directly linked to community agencies providing services. Adding further to the problems is the fact that the cadre of faculty members who developed expertise in various aspects of gerontology have found that as a result of the declining student demand, reductions in funding, and lack of coordination they have been effectively dissociated from the gerontological enterprise. This project provided a mechanism whereby such faculty could be redeployed and incorporated into a functioning knowledge dissemination and service delivery system.

Rapid growth in the need for an aging services delivery system has created equally vexatious difficulties. The number of professional and para-professional service providers required to deal with the quickening need for staff has resulted in a situation where personnel have been placed in positions with little previous training or else with an inability to remain current in their fields. The training project undertaken here, under the auspices of AoA, was designed to address this shortcoming directly. Aimed at senior center directors, information and referral counselors, day care and nutritional site managers and workers, recreation directors, escort, companion, respite and home health aides plus the entire melange of social services personnel, the in-service, on-site training programs we provided are felt to have been a

major step in improving competencies, expertise, morale and ultimately the services provided to older clients. In addition to the target groups stipulated at the onset of the grant period, a variety of other community agencies also received training and benefits from the program. Among the latter were: mental health workers, adult day care workers, nursing home staff and a variety of paid and volunteer providers in religious, civic and community organizations. Provided they were directly involved in providing services to the elderly, no agency, unit or organization was deemed to be ineligible.

OPERATING METHODOLOGY

Operationalization of this training project was carried out in three distinct phases, each with a self-contained time frame, each under the direction of an "oversight" advisory committee.

Phase I Course Preparation and Selection of Volunteers

Step 1. Preparation of 28 hour courses in each of five priority areas.

Based on the State Comprehensive Needs Assessment Study, five priority areas where training was needed were selected. The particular areas chosen were based on the identification of deficiencies noted by the State Office on Aging and the congruent expertise represented by faculty members willing to participate at the University of Kentucky.

Step 2. Identification and recruitment of Retired Professional Volunteers to Receive Training

Following receipt of the award from AoA, a series of news releases were prepared by project staff and the University of Kentucky's News and Information Services. These were published in local newspapers, professional newsletters, and mailed directly to organized groups of retired professionals. An estimated 290 letters and information packets were sent to agencies or individuals identified as potential sources of volunteers. Over a period of several weeks a number of telephone and written inquiries were received. An approximate count was kept and our best estimates are that in excess of 200 retired persons requested additional information. In all instances four general criteria for volunteer selection were outlined: previous teaching experience or good communication skills; public speaking experience; previous background or interest in one of the five priority areas; a strong interest in community service. Of the original number, 90 plus completed applications were received for 36 positions carrying an honorarium of $500.00. During a three-week period in January and February, 1985, 66 interviews were held in eleven group sessions. At the conclusion of this process, 36 persons were invited to participate and receive the honorarium; an additional seven persons were invited to participate as alternates (though only five did so) to compensate for any possible attrition. These persons selected as alternates did not receive the honorarium, they were reimbursed for expenses stemming from their participation in the project, however. With attrition along the way kept to a minimum, 40 persons completed all six training sessions.

For the purposes of the group interviews, an evaluation form was developed on which project staff could record their impressions of applicants' general suitability for the program. At least three members of the project staff were present for all interviews: one or the other of the two principal investigators, the project administrative assistant and the research associate. All interview sessions followed a similar format designed to make the applicants feel at ease, inform them of the nature of our program and solicit information and reactions from them. Upon completion of all interviews rater scores were discussed and a preliminary decision made as to the initial order of invitations to participate. These decisions reflected the applicants' characteristics as well as the training needs of the project. All potential participants were informed of the decision by phone or by letter with those who were invited to participate contacted by phone. Originally ten alternates were also contacted. Both regular participants and alternates were mailed a "mock" contract, stipulating that they agreed to participate in all training activities, undertake a full six months of field trips and in every way possible represent the program to the best of their ability (see Appendix D). Apparently this "contract" had real meaning to the older volunteers as several mentioned its importance to them.

Of the 66 retired persons who came in for interviews; three were presently employed in some capacity and were therefore ineligible; three withdrew from the opportunity to participate prior to

notification; five withdrew prior to the beginning of the training period; two declined alternate positions when offered; three withdrew during the period of training--two of these were alternates and one a regular participant. At the conclusion of the training, 35 regular and five alternate volunteers had completed all phases of the training process.

Step 3. Development and Dissemination of Information Brochure

Also included in this initial phase of the project was the development and distribution of an INFORMATIONAL ANNOUNCEMENT of the availability of the in-service training programs. A "flyer" explaining the five priority areas, application procedures, stipulations, scheduling, etc. was prepared and widely distributed across the state (see Appendix C). Local contacts were established with the assistance of the Kentucky State Division of Aging Services, local aging planners located in each ADD, and the University of

Kentucky's own Cooperative Extension Service, which maintains agents in each of the state's 120 counties.

PHASE II: Volunteer Training and Workshop Scheduling

Step 4 Administration of Training Courses in Five Priority Areas

Prior to beginning the actual training of the older volunteers, project staff and instructors met for a series of meetings dealing with course content, evaluation procedures and a two-hour briefing

on characteristics of older persons as students. The latter focused specifically on age-graded instructional needs, the need for repetition, active participation, trial presentations by the older volunteers, the prospect of anxiety as a hurdle in optimum learning, techniques of "damage control" when anxiety was expressed and the risks involved with any type of "compressed" educational experience. Above all, the project staff wanted to make the educational portion a meaningful experience for the older volunteers while avoiding the pitfalls of creating a cadre of "instant experts." These briefing sessions were assessed to have been particularly valuable insofar as they sensitized the instructors to possible difficulties and allowed a sharing of experiences between those who had previously taught in situations where older students were involved, and advance exposure to a range of issues for those who had not yet had such opportunities.

As will be pointed out below, the instructors reported at the conclusion of the training that the experience ranked among the very best they had ever had as instructors. The older volunteers were committed, challenging in their questions and dedicated in a way most instructors felt was atypical. This is not to say there were not problems, there were. Overall, however, the forty older volunteers helped create an atmosphere the instructors found to be a uniquely rewarding teaching experience.

The actual training took place over six Saturdays with a two week break in the middle necessitated by a holiday weekend and a

local collegiate event which monopolized hotel and lodging space for a considerable radius. All sessions were held on the main campus of the University of Kentucky at a central location. Coffee was available for thirty minutes prior to the sessions, during a coffee-break and for a brief period at the end of the sessions. This enabled project staff, instructors, and older students to interact informally, deal with issues as they arose and permitted the older students to get to know one another prior to the necessity of traveling together to distant sites around the state.

With two exceptions the sessions lasted for four hours. The two exceptions consisted of additional two hour plenary sessions. The first plenary session was a two-hour teaching skills workshop presided over by a health professions teaching/training specialist and was designed to provide a summary overview of teaching techniques the older volunteers could adopt for the purposes of their own field presentations. Included were principles and techniques of lesson planning, presentation skills identification and implementation of objectives. The final plenary session came on the last day. It was intended to summarize the focus of the project, procedures for scheduling, decisions regarding substantive presentations in the field, reimbursement rules, and a variety of procedural details. A complimentary lunch was provided on these two occasions. Prior to any substantive discussions at the first session and at the final meetings the first two waves of the evaluation instrument were administered.

At the conclusion of the training all volunteers were presented with a certificate of completion (see Appendix E). to indicate they have received the full complement of training under the program.

Substantive Content

The five priority areas in which instruction was provided were: (1)home health care/nursing, (2)consumer economics, (4)drug use and medication practices, (4) coping skills, and (5) nutrition and food preparation.

The actual content of these courses was determined through consultation with the training officer of the State Office on Aging and the instructors responsible for each course. Multiple drafts of course outlines were submitted, for review, and critiqued by the Advisory Committee. Each content area was designed with an eye toward the training needs identified by the 1984 Training and Education Plan for the Commonwealth of Kentucky in the State Office on Aging needs assessment. The five priority areas were selected on the basis of faculty expertise from among the 21 cognate areas deemed most in need of additional training and skills up-dating.

In terms of priority areas, the number of presentations was as follows:

Coping Skills and Adaptation 40

Home Health and Nursing	30
Nutrition and Food Preparation	26
Drugs and Medication Practices	26
Consumer Economics	25

Step 5 Scheduling of Workshops

The scheduling of in-service training sessions was an on-going activity lasting throughout the duration of the grant. Initially a mailing was made to an extensive list of approximately 250 programs or agencies across the state. At subsequent stages additional announcements were also made through the News and Information Service of the University of Kentucky and through monthly newsletters of the State Office on Aging and a wide range of other professional-level organizations. Efforts to advertise the availability of the no-charge training among appropriate programs and agencies continued through the nearly six months of the field trips.

With the assistance of the University of Kentucky's Cooperative Extension Service, and the Kentucky Division of Aging Services information was disseminated in each of the 15 Area Development Districts (ADDs) of the state (see Appendix F) and in all 120 counties.

At the conclusion of the project, 147 presentations had been

made in 42 separate Kentucky sites or counties, at 34 different cities, and to a total of 59 independent agencies. Almost exactly half of all presentations were made in the state's two largest metropolitan areas or in the surrounding suburban areas. An additional 23 agencies requested information but were ultimately incorporated into other scheduled presentations. Four requests were cancelled after initial scheduling and two substituted some other form of in-service training. Overall, the project had 83 contacts with aging related agencies across the state--ranging from nursing homes, hospitals and health departments to community action agencies and aging service centers. Also included, however, were such groups as the Kentucky Retired Teachers Associations, religious and church related groups and a Visiting Nurse Association.

All requests for training were channeled to a coordinator who responded to written or telephone inquiries, following-up with a written request and data sheet, scheduled the appropriate volunteer trainer and served as the point of contact between program project staff, those requesting training, and the older volunteers.

During the six months of the field trips the older volunteers provided a total of 147 workshop presentations. An estimated total of roughly 3000 individuals, including paraprofessionals, registered and licensed practical nurses, nursing home and service program administrators, were exposed to training in one to five of

the priority training areas. The average estimated attendance was 20 persons per workshop. In terms of the scheduling of the workshop presentations, the first three months were approximately equal with between 11 and 15 presentations per month. This figure climbed to 28 in August, 38 in September and 36 in October. During November an additional 8 workshops previously scheduled were also presented. On the average, each retired volunteer presented 3.8 workshops with a maximum of 9 presented by any one individual.

PHASE III: Program Evaluation

A third phase of the project consisted of a series of evaluation measures coordinated by an independent evaluator who, though supported in part by grant monies, functioned as objective observer for the project. Under the evaluator's direction, pre- and post-test measures were formulated for assessing the impact of participation of the older volunteers. These measures consisted of a series of life-satisfaction and morale measures as well as measures of their knowledge of substantive content in those areas where they received training and delivered in-service workshops. Three data points were determined to be appropriate: at the first meeting of the on-campus training series, at the conclusion of the training, and again six months later in what we termed the post-field experience test.

In addition to the formal evaluations, informal review was pro-

vided by course instructors. Each was asked to rank-order the older volunteers who had participated in their particular area and to alert project staff to any potential difficulties they might envision with individuals or their group as a whole. This information was utilized to better match requests for presentations with the most appropriate volunteer.

Under the direction of the evaluator an effort was also made to assess the impact of the retired volunteers in the delivery of in-service training. In cooperation with local agency administrators a series of short evaluation instruments were administered on-site, and return mail questionnaires were provided to local coordinators or supervisory personnel. Our response rate to the latter request was considered good at 63 percent (92 out of 147).

EVALUATION OF THE PROJECT

Training Received by Volunteers

Volunteers were trained by University of Kentucky faculty during six sessions held during March and April, 1985. They received twenty-four hours of instruction in an area of specialization and four hours of instruction on effective techniques for oral presentation of information. Training was completed by forty volunteers, thirty-nine of whom remained active in the program.

The effectiveness of instruction was judged in part by staff members' observations of volunteers' reactions. Their unanimous

conclusion was that reactions were very positive. Class discussions were generally lively, and discussions carried over into breaks. Levels of interest were judged to be consistently high. Volunteers' responses to questionnaire items supported the staff members' perceptions. Immediately following the last class session, volunteers completed a questionnaire containing, among other things, five items concerning their evaluations of the training they had received. At the end of the project, two additional items gave volunteers an opportunity to express their opinion of the training after they had witnessed its success in preparing them for workshops they had been responsible for conducting. The items used at the end of training had possible responses of strongly agree (scored 1), agree (2), disagree (3), and strongly disagree (4). Items asked at the end of training had possible responses ranging from very satisfied (1) to very dissatisfied (5). Responses are summarized in Table 1.

Table 1. Volunteers' Evaluations of Instruction

	Mean	Standard Deviation	Median
Items Asked at End of Instruction*			
I believe I have a good grasp of the subject matter that has been presented	1.58	0.50	1.63
Materials were presented clearly and in a way I could understand	1.23	0.42	1.14
Reading materials and handouts were useful and appropriate	1.20	0.40	1.12
I know more about the subject of the workshops than I did two months ago	1.10	0.31	1.06
I am confident of my ability to present materials from my area of specialization to an audience	1.55	0.50	1.59
Items Asked at End of Project**			
Please indicate how satisfied you are [with] the training you received	1.28	0.51	1.17
How satisfied are you with the support you received from the training faculty during your time in this project?	1.28	0.60	1.15

* Scored 1-4
**Scored 1-5

As the table shows, volunteers evaluated their instruction in very positive terms. The only items on which any hints of apprehension appeared are those reflecting the volunteers' beliefs that they grasped the subject matter and were prepared to present it to an audience. It is therefore important to note that the positive evaluations of instruction had not declined at the end of the project. After giving presentations, volunteers seem to have felt that their instruction had served them well.

As the positive evaluations would suggest, the volunteers appear to have gained some knowledge as a result of their participation in the project. At three points in time -- before the first instructional session (Time 1), at the end of the instruction (Time 2), and at the end of the project (Time 3) -- volunteers were asked to answer questions involving "facts on aging" (Palmore, 1977) and the specific subject matter in which they had been trained. Palmore's quiz was developed in part to estimate knowledge of and bias toward aging. Attempts to validate the quiz have generally been successful, suggesting that the quiz is useful for measuring knowledge about aging (e.g., Palmore, 1980; Luszcz, 1982). Some suggestions have been made for rewording items to make them more understandable to respondents (e.g., Miller and Dodder, 1980). Several such suggestions were followed for this study. Specific items used are shown in an Appendix to this report. Questions on specific subject matter were developed by the program's instructors. They received general instructions

regarding format, but they were encouraged to use their own expertise in choosing specific items.

As Table 2 shows, the volunteers, regardless of their area of specialization, achieved higher average scores at the end of instruction than they had attained at the beginning of the program. Changes between Times 1 and 2 were significant ($p<.05$) for the "Facts on Aging" quiz, Consumer Economics, Drugs & Medication Practices, and Home Health Care & Nursing. At the end of the program, average scores for all areas remained higher than those obtained at the beginning. However, only the "Facts on Aging" quiz and quizzes in Coping Skills & Adaptation and Nutrition & Food Preparation resulted in a maintenance of the level obtained at the end of instruction. It is encouraging to note that none of the decreases was significant and that scores for "Facts on Aging," Consumer Economics, Home Health Care & Nursing, and Nutrition & Food Preparation were significantly higher at time 3 than they had been at the beginning of the project. In general, the impact of instruction on knowledge of subject matter was a lasting one, but some slippage occurred after volunteers left the classroom.

A related issue requiring comment is the level of the quiz results. If the volunteers had been graded on the 10 point scale used at many universities, no class would have attained an average higher than C. In one group, the mean score was failing by most criteria. These results introduce some concerns about

whether the volunteers were qualified to present workshops to others. It should be recalled, however, that the volunteers are not in an age group for which taking exams is an everyday occurrence. The fact that instructors had to choose exam questions before they presented the material could also have distorted the results. Nevertheless, it is important to examine evaluations of the workshops presented by volunteers. We turn to this topic in the next section.

Table 2. Results of Quizzes Administered to Volunteers

	Time 1		Time 2		Time 3	
	Mean	s.d.	Mean	s.d.	Mean	s.d.
Facts on Aging[1&3] (N = 39)	.699	.087	.767	.094	.769	.099
Consumer Economics[1&3] (N = 9)	.599	.084	.749	.064	.696	.102
Drugs and Medication Practices[1] (N = 6)	.467	.080	.550	.045	.533	.068
Coping Skills and Adaptation (N = 9)	.657	.140	.686	.123	.710	.092
Nutrition and Food Preparation[3] (N = 7)	.623	.065	.680	.083	.749	.079
Home Health Care and Nursing[1&3] (N = 8)	.469	.119	.644	.140	.637	.103

[1] Scores for times 1 and 2 differ ($p<.05$)
[2] Scores for times 2 and 3 differ ($p<.05$)
[3] Scores for times 1 and 3 differ ($p<.05$)

s.d. = standard deviation

Workshops Delivered by Volunteers

Overall the workshop coordinators judged the training provided by the GEP volunteers to be quite good. Table 3 provides an overview of their evaluation responses. Forty-seven percent of the evaluators judged the volunteers' command of the subject matter to be "excellent" (A) on the five point scale ranging from "excellent" to "failure" (see Appendix G).

An additional 39 percent gave a rating of "B". Only two percent gave a rating lower than a "C". The evaluators were similarly complimentary of the effectiveness of the volunteers' presentations. Over half (52 percent) felt the presentations were worthy of an "A", and 30 percent more felt they were good enough for a "B" evaluation. Again, the number feeling the presentations to be of less than average quality "C" was small at four percent. The training was generally seen as appropriate with over 80 percent judging it as either an "A" or "B". Five percent seriously questioned the topic appropriateness, making below a "C".

One of the questions asked gave the evaluator the opportunity to show his/her interest in having additional training (in the same or different topic areas) provided by the GEP volunteers. It could also be seen as a validity check for responses to the items discussed above. As such, the results provide considerable support. Seventy percent were "very interested" in hearing addi-

tional presentations and 20 percent more were "somewhat interested". No one was "not at all interested".

The last evaluation item asked how much experience or training the coordinator/evaluator had in the subject matter being presented. Eighty-seven percent claimed to have had either "a great deal" or "some" experience and/or training. This data also seems to lend support to the validity of earlier responses. If the evaluators judged themselves to have little or no knowledge of these topics, their generally positive views could easily be seen as uninformed and inflated: those of people unable to make a meaningful assessment of either the topic appropriateness or content. Instead, however, the evaluators believe themselves to be reasonably well acquainted with the topics. Presumably they would be seen as apt evaluators.

Table 3. Assessment of Volunteer Training (Numbers of Respondents)

	A	B	C	D	E
Volunteer's Command of Subject Matter	47%(43)	39%(36)	12%(11)	1%(1)	1%(1)
Effectiveness of the Volunteer's Presentation	52%(48)	30%(28)	13%(12)	3%(3)	1%(1)
Appropriateness of the Presentation for Audience	50%(45)	31%(28)	14%(13)	3%(3)	1%(1)

	Very Interested	Somewhat Interested	Not Very Interested	Not At All Interested
Interest in Hearing Additional Presentations	70%(59)	26%(22)	4%(3)	0%(0)

	Great Deal	Some	Little	None
Amount of Training or Professional Experience of Evaluators	35%(30)	52%(45)	8%(7)	5%(4)

Table 4 presents a comparison of the evaluation means for each of the five content areas in which volunteers were provided training. The presentations in the areas of Home Health and Nursing Care, and Coping and Adaptation seemed to have been particularly well received by the field coordinators. Both showed means "below" the overall means for each of the three questions relating specifically to the training sessions, and also in the amount of interest indicated in hearing additional presentations. It may be important to note that the content area with the most favorable score regarding appropriateness for the audience was Consumer Economics (1.53). Earlier it was suggested that the areas incorporated under this topical heading may not be seen as the most relevant to their clients by agencies/organizations who were scheduling training. However, it appears that, once exposed in more detail, the perceived relevance undergoes a marked change. Why this occurs is unclear. It may, however, ironically have to do with a general unfamiliarity with consumer economic issues. This notion would be supported by the data which shows workshop evaluators to have had less training and experience (2.13) in this area than any of the other four.

Table 4. Mean Evaluation Scores for Five Priority Areas

	Total (N=92)	Consumer Economics (17)	Coping/ Adaptat (27)	Drugs/ Medicat. (17)	Home Health (16)	Nutr/ Food Prep (15)
Volunteers Command of Subject Matter	*a 1.71	1.77	1.67	1.77	1.50	1.87
Appropriateness of the Presentation for Audience	*a 1.71	1.82	1.52	2.00	1.50	1.80
	*a 1.78	1.53	1.73	1.94	1.75	2.00
Interest in Hearing Additional Presentations	**a 1.33	1.29	1.42	1.33	1.20	1.39
Amount of Training or Professional Experience of Evaluators	**b 1.83	2.13	1.69	1.80	1.80	1.79

* Possible range of 1-5.
** Possible range of 1-4.
a The lower the score the more positive the evaluation.
b The lower the score the greater the amount of training or professional experience.

In addition to completing the evaluations, several individuals, representing agencies who hosted workshops, wrote letters to the GEP or individual volunteers. These letters were overwhelmingly supportive of the GEP with several requests for training opportunities to be continued.

Of course, no project of a large scope can hope to be conducted without problems. The GEP was no exception. The two most germane were voiced both by the project staff (including volunteers) and the workshop evaluators. First, communication among the staff, volunteers, and hosting agencies was not always as clear as it could or should have been. On several occasions, for example, requested audiovisual equipment was not provided. The training environment was occasionally also less than adequate. Likewise, in a few instances, the topical area requested by the hosting agency and the presentation offered by the GEP volunteer were not well matched. While these problems abated as the project progressed, they still merit attention.

The second concern is the potential for mismatch between the level of training needed versus the level offered. Data presented earlier would appear to leave little doubt that the training provided was generally timely and appropriate. Yet, in addition to the occasional misunderstanding of what topic was requested, there were instances of presentations being too basic to be of any real benefit to those attending. Two workshops, in

fact, were cancelled for this reason once the first of three scheduled had been completed.

Just how much to make of this issue is difficult to know. Certainly no program can be all things to all people. The GEP never was intended to provide training in areas where individuals already had a professional background, e.g. home health care for nurses or drugs and medications for pharmacists. On the other hand, providing these groups with up-to-date information on coping and adapting issues and strategies for the elderly seems appropriate and viable. Overall, the project seems to have done a good job of targeting itself. This issue does, however, raise several questions, including the following:

1) Should a project such as this use only volunteers with backgrounds in the respective content area?
2) How much material can one be expected to assimilate in a meaningful way in 20-30 hours of training?
3) What types of support materials should be developed for the volunteers?

The Impact of Workshops

Impact on Organizations and Communities. Practitioners in human service delivery are in frequent need of help to keep their knowledge and skills current and to maintain their enthusiasm in what can be a demanding job. Funds for professional development are exceedingly limited, however. A service providing current

information and training at a cost that agencies employing the practitioners could afford would therefore be making an important contribution. At the same time, a danger exists that a "free" service would introduce inaccurate, inappropriate, or poorly presented material. The evaluations reviewed in the preceding section indicate that the contributions of this project to the agencies and their employees were generally positive. To be sure, some problems were encountered. Particularly during the early weeks of presentations, some volunteers arrived at workshop sites with inaccurate expectations of the nature of the audience they would be addressing or the type of program in which they would be participating. As a result, a few audiences expecting to hear relatively technical and specific presentations were given general presentations addressed to individuals with less training and experience. While such problems are unfortunate, they are probably inevitable during the early phases of any project. They resulted in an increased understanding on the part of the University's office of the need for coordination with workshop organizers. For the most part, organizers and (when surveyed) audience members viewed the presentations as worthwhile. Significantly, most organizers indicated an interest in having future presentations from volunteers in this project.

While the information available to us suggests that the Gerontology Extension Program exerted a positive impact on the organizations and communities in which presentations occurred,

two caveats are in order. First, we have no measure of the extent (if any) to which the project affected services delivered by those who heard the presentations. We would expect that the short-term effects would be very small. Presentations involved factual information rather than instruction in the performance of specific tasks. While they may have affected the information base and attitudes of audience members, the translation of attitudes into behavior is always problematic. In this case, specific behavior by service deliverers is likely to be influenced more strongly by an organization's procedures and facilities and by the individuals' prior training and socialization than by a relatively short presentation. Despite our modest expectations for behavioral impact, however, we view exposure to current information as important in maintaining appropriate practices as well as receptivity to future improvements in practice. The generally positive evaluations of the presentations suggest that they could have helped set the stage for future improvements in service. Second, it should be noted that the volunteers' presentations approached their subject matter at introductory and intermediate levels. This pilot project was not designed to demonstrate that retired volunteers can be used to offer intensive advanced instruction. We suspect that paid professionals will continue to be necessary for this purpose.

Impact on Volunteers. In any project using the services of unsalaried volunteers, it is essential to examine their reactions

to the experience. While the volunteers in this project received reimbursements for travel expenses and a small stipend for participating in training, trained professionals would expect to receive far greater compensation for the services they provided. In view of the meager monetary rewards, it is important to determine whether the project carried other, more subjective benefits for the volunteers. In more negative terms, it is important to determine that the volunteers did not find the experience emotionally traumatic or harmful. While the literature on voluntary action generally notes positive benefits from such experiences, inappropriate assignments and expectations can be harmful.

As was noted above, the volunteers responded positively to the training they received, and their scores on the "Facts on Aging" and substantive quizzes suggest that they received an intellectual benefit from the project. In addition, we examined their assessment of a number of specific components of the volunteer experience and changes in their attitudes about themselves as social actors.

A scale developed by Payne and Bull (1977) was modified so that items would be appropriate to this project, and volunteers were asked to respond to it on the final questionnaire. Results from the 37 volunteers responding to all 25 items are summarized in Table 5. Possible responses ranged from very satisfied (scored 1) to very dissatisfied (scored 5). Items are listed beginning with two receiving the most favorable response and end-

ing with one receiving the least favorable response from the volunteers as a whole. As the table shows, volunteers derived a general sense of personal satisfaction from the project. They were quite satisfied with the activities they performed and with the project's professional staff (administrative and teaching). They were less satisfied with their opportunities for contact with other volunteers and for close involvement in program planning and administration. These concerns are probably inevitable outcomes of the geographic dispersion of the program and its volunteers. Partly because of geographic dispersion, the volunteers encountered expenses during their participation, and they were not completely satisfied with the reimbursements they received. The responses also reveal a degree of skepticism on the volunteers' part about the effectiveness of the program for solving the problems of the elderly and about their own personal effectiveness. While some areas of concern clearly exist, it should be noted that even the relatively "unfavorable" items received responses that approached satisfaction much more closely than dissatisfaction.

Table 5. Volunteers' Evaluations of Project Components

	Mean	Standard Deviation
Contact with program staff	1.162	.374
Support from project staff	1.162	.374
The training you received	1.243	.435
Chance to be your own boss	1.270	.450
Support from training faculty	1.270	.608
Personal satisfaction of helping others	1.270	.693
Physical demands involved	1.378	.492
Executing your own ideas	1.378	.492
The particular kind of work you did as a volunteer	1.378	.594
Opportunity to discuss problems of the elderly	1.432	.502
Supervision or direction you received	1.432	.555
Ways the volunteer program made use of your skills and talents	1.568	.728
Effectiveness of communication with local site coordinators	1.595	.686
Demands made upon your time	1.595	.686
Chance for recognition from the volunteer organization	1.622	.492
Your ability to do a good job of addressing requested topics when you presented workshops	1.649	.538
Your ability to help the recipients of your services	1.649	.588
Your overall performance when presenting workshops	1.676	.580

Table 5 (continued)

Contact with other volunteers	1.703	.845
Money you received for expenses	1.757	.723
Recognition for being a volunteer from the community, neighbors, or state	1.865	.713
Opportunities to share ideas with other volunteers	1.946	.815
Opportunity to do something about the problems of the elderly	1.973	.897
Chance to be involved in the planning of programs	2.054	.780
The number of workshops you conducted	2.243	1.164

Several scales were used to provide additional measures of volunteers' subjective reactions to their experiences. In each case, the scale was included in questionnaires administered at the beginning of the project, at the end of training, and at the end of the project. Self-esteem, referring to self-acceptance or a basic feeling of self-worth, was measured by a ten-item scale developed by Rosenberg (1965). (Items for this and other scales are shown in the Appendix.) Several demonstrations of the scale's reliability and validity have led Breytspraak and George (1982: 257) to recommend the scale as "a useful measure of global self-esteem." We used Cronbach's alpha to test the reliability of this and other scales, and the results for self-esteem were quite satisfactory. Alpha values obtained were .814 (time 1), .851 (time 2), and .826 (time 3).

Morale was measured using a revised version of the Philadelphia Geriatric Center Morale Scale (Lawton, 1975). The scale was developed on the assumption that high morale reflects a sense of satisfaction with oneself, a feeling that one has a place in the environment, and a willingness to accept those things that cannot be changed. The revised version of the scale has shown evidence across several samples of reliability, validity, and factor structure stability, but it is not clear that it fully taps the domain of morale (Sauer and Warland, 1982: 228). Our administration of the scale to this projects' volunteers did not lead to straightforward evidence of reliability or of a factor structure consistent with that reported in the literature. For the scale as a whole, we found that reliability was maximized when only 13 of the 17 items in Lawton's revised version were used. While Lawton identified three factors -- agitation, attitude toward own aging, and lonely dissatisfaction -- we were able to obtain acceptable measures of reliability for lonely dissatisfaction only. (Lawton used six items from his revised scale to develop this factor. Our reliability coefficients were most satisfactory when we used only the four items shown in Appendix H.) Additional factors from the scale have been developed by Morris and Sherwood (1975), but they did not obtain adequate reliability scores for our sample.

Reliability coefficients (Cronbach's alpha) for the measures of morale used in our study were: for the general morale scale,

.595 (time 1), .697 (time 2), and .684 (time 3); for lonely dissatisfaction, .874 (time 1), .795 (time 2), and .673 (time 3). While these are not as high as those reported in the literature, it should be kept in mind that our sample is quite different from the residents of public housing and institutions studied by Lawton.

Social Alienation was measured on the basis of a subset of a morale scale developed by Clark and Anderson (1967). Pierce and Clark (1973) submitted the scale to a cluster analysis after it had been administered to elderly community-dwelling subjects and hospitalized subjects in San Francisco. For both categories of respondents, a "social alienation" dimension (reflecting a "sour and pessimistic disposition") emerged. Sauer and Warland (1982: 213) have been unable to locate formal tests of reliability for the scale. Our own results suggest a need for some caution. After deleting two of the original seven variables because of low internal consistency, we obtained alpha coefficients of .552 (time 1), .551 (time 2), and .656 (time 3). While we consider these indications of reliability only marginally acceptable, we present the results for social alienation to allow an examination of the volunteers' willingness to endorse negative statements.

Perceptions of Health were measured using items developed by Ware (1976). Respondents were asked to indicate the extent to which thirty-two questions about health were true or false for them. Ware's research suggests that the items can be combined to

provide information about six variables -- current health, prior health, health outlook, health worry/concern, resistance-susceptibility, and rejection of sick role. For this sample, factor analyses failed to yield several of Ware's variables, but factors resembling current health and prior health did emerge. Our current health scale contains seven of the nine items in Ware's scale and yields Cronbach's alphas of .776 (time 1), .874 (time 2), and .901 (time 3). Our prior health scale contains all three items from Ware's scale and yields Cronbach's alphas of .688 (time 1), .743 (time 2), and .763 (time 3). We also found that twenty-two of the items from the overall instrument could be combined to form a measure of general health perceptions, with alpha values of .804 (time 1), .854 (time 2), and .832 (time 3).

Results for the three administrations of these scales are summarized in Table 6.

Table 6. Attitudes of Volunteers

	Time 1		Time 2		Time 3	
	Mean	s.d.	Mean	s.d.	Mean	s.d.
Self-Esteem (N = 39)	34.378	3.861	34.919	4.119	35.108	4.074
Morale[2] (N = 32)	24.625	1.540	24.687	1.712	24.219	1.930
Lonely Dissatisfaction[3] (N = 36)	7.861	.593	7.806	.624	7.750	.649
Social Alienation[1] (N = 39)	6.744	1.758	6.231	1.613	6.487	1.998
Current Health (N = 36)	27.944	4.174	28.111	4.833	26.861	5.581
Prior Health (N = 37)	10.757	3.796	10.514	4.066	10.514	4.066
General Health (N = 37)	87.333	9.545	87.333	10.558	85.879	10.505

[1] Scores for times 1 and 2 differ ($p<.05$)
[2] Scores for times 2 and 3 differ ($p<.05$)
[3] Scores for times 1 and 3 differ ($p<.05$)

s.d. = standard deviation

As the table shows, changes in attitudes were sometimes significant but seldom dramatic. Except for social alienation, higher mean values indicate greater well-being. Only one variable -- self-esteem -- showed consistent improvements over time, and the differences between its mean values were not significant. A more typical pattern, seen in the cases of morale, social alienation, and current health, is for an improvement during the first portion of the project to be followed by some deterioration by the end of the project. It is very important to note, however, that the volunteers' emotional states were very favorable throughout the life of the project. Indeed, their initial scores were so high (approaching the maximum possible value for most scales) that the project could have done little to encourage improvement. It is likely that social-psychological improvement would have been more evident if efforts to recruit only well-qualified and well-adjusted volunteers had not been made. This is a clear case of the necessity (from administrative and ethical viewpoints) of providing a worthwhile service to consumers of workshops taking precedence over the scientific need for a more representative sample of the older population in Kentucky.

Table 7. Predictors of Volunteers' Attitudes

	Self-Esteem			Morale		
	Time			Time		
	1	2	3	1	2	3
Age	.234	.245	.204	.460*	.312*	.345*
Gender[1]	-.081	-.179	-.201	-.011	.088	-.182
Graduate Work	.513*	.548*	.463*	.477*	.177	.419*
Marital Status[2]	-.106	-.116	-.176	-.200	.114	-.062
Number of Workshops Conducted	-.195	-.230	-.140	-.249	-.246	-.325*
Consumer Economics	-.091	-.086	-.057	-.115	-.237	-.100
Drugs and Medication Practices	.147	.173	.197	.304*	.260	.179
Coping Skills and Adaptation	.289*	.206	.186	.116	.050	.164
Nutrition and Food Preparation	-.122	-.133	-.056	-.006	.213	.062
Home Health Care and Nursing	-.209	-.166	-.250	-.282*	-.261	-.303*

Table 7 (continued)

	Lonely Dissatisfaction			Social Alienation		
	Time			Time		
	1	2	3	1	2	3
Age	.444*	.460*	.444*	-.184	-.356*	-.364*
Gender[1]	-.248	-.004	-.175	-.160	-.035	.034
Graduate Work	.662*	.348*	.495*	-.346*	-.347*	-.398*
Marital Status[2]	.037	.039	-.082	.165	.194	.135
Number of Workshops Conducted	-.180	-.148	-.161	.082	.109	.232
Consumer Economics	.155	.063	.000	-.094	-.079	.173
Drugs and Medication Practices	.120	.129	.175	-.142	-.106	-.177
Coping Skills and Adaptation	.155	-.039	.209	-.059	.035	-.074
Nutrition and Food Preparation	-.078	.029	-.137	-.200	-.152	-.183
Home Health Care and Nursing	-.356*	-.167	-.247	.478*	.285*	.229

[1]Male=0; female=1
[2]Single or widowed=0; married=1
*$p < .05$

Despite the generally favorable attitudinal situation of the volunteers, they did not enter the project on an absolutely equal basis. We used several demographic characteristics of volunteers, their level of participation in the project (as measured by number of workshops presented) and the area in which they received training in an effort to predict attitudes and changes in attitudes during the course of the project. Table 7, which summarizes correlates of several attitudes at three points in time, shows that older volunteers and those with work beyond the Bachelor's degree tended to enter the program with favorable outlooks and to retain them. While patterns are less clear-cut when the training areas are compared, those assigned to Coping & Adaptation and Drugs & Medication Practices appear to have started with some social-psychological advantages while those in the Home Health Care area began with lower levels of adjustment. Because of few significant relationships, results regarding health-related attitudes are not shown in Table 7. They would justify few conclusions except that no category of volunteers was dominated by hypochondriacs.

The ability of the variables summarized in Table 7 to predict changes in attitude over time was also examined. Females had a tendency to decline in self-esteem during the period of initial instruction ($r = -.284$) but, more encouragingly, to become more likely to avoid feelings of lonely dissatisfaction ($r = .292$). Volunteers with some graduate work revealed a tendency

to lose morale (r = -.396) during the same period. Age was seldom useful for predicting change, but older volunteers had a tendency to lower their opinion of their prior health during the course of the overall project (r = -.316). Married volunteers had a tendency to improve their morale (r = .305) and the "lonely dissatisfaction" component of morale (r = .280) during the instructional phase of the project. The subject matter of training was seldom associated with change, but those in consumer economics tended to experience increased alienation (r = .284) and reduced feeling of general health (r = -.308) during the overall course of the project. Coping & Adaptation training was associated with reduced feelings of current health during the overall project (r = - .329). Those in Nutrition experienced increased morale during the period of their training (r = .319). A negative correlation between participation in the Home Health Care program and change in alienation during the period of instruction (r = -.265) approached significance at the .05 level. In general, however, changing attitudes were difficult to predict on the basis of variables available to us. It is particularly surprising that the number of presentations given by volunteers did not significantly predict changes in attitudes. If the .05 level of significance were abandoned in favor of the .1 level, however, it would be possible to report that the number of presentations was associated with improved scores on the "lonely dissatisfaction" component of the morale scale (r = .239) and with an improved view of one's prior health (r = .237).

CONCLUSIONS AND RECOMMENDATIONS

Volunteers appear to believe that they received good training and opportunities to participate in interesting activities during the project, and most of those who organized the workshops in which volunteers gave presentations appear satisfied with the quality of presentations given. The volunteers may have felt somewhat isolated from each other during the period following their training, and they were not completely convinced that their presentations served to alleviate problems of the elderly or that they performed as effectively as possible. Their attitudes regarding themselves as social actors were not measurably improved by their participation in the project, but they entered with attitudes that can only be considered highly favorable. Opportunities for improvement were therefore negligible. In contrast, their knowledge about aging and the specific subjects in which they received training was enhanced as a result of their participation. Despite a ceiling effect, the project appears to have been a moderately favorable experience for volunteers whose lives were already rewarding and a source of useful services for agencies in a poor position to finance training for their staff. During the course of the project, university officials learned valuable lessons about coordination with local offices and about the comparative ability of individual volunteers to deliver presentations of high quality. The available evidence suggests that the quality of services provided would only improve if the project were allowed to continue.

The information available at this point in time leads us to recommend the Gerontology Extension Program as a model for using the expertise of retired professionals to provide information and training to staff members of human service agencies. The relatively short workshops that volunteers in such a project can be expected to deliver should not be considered a substitute for more intensive advanced training that can be delivered by paid professionals. However, the Gerontology Extension Program does provide a useful and economical model for beginning to share some of the resources of universities with outside agencies.

While major alterations in the organization of the Gerontology Extension Program do not appear necessary, several suggestions might be useful if additional funds are found for the program at the University of Kentucky or if officials of other states wish to adopt this model. We recommend that continuing efforts be made to improve communication (in advance of workshops) between workshop coordinators and the volunteers. It is essential that volunteers understand the nature of their audience and the level of information they are expected to deliver. We also recommend that project administrators develop techniques to encourage a continuing sense of involvement on the part of volunteers. Monthly newsletters and periodic workshops focusing on refreshers and updates regarding substantive information and instructional techniques would promote a sense of involvement and help to maintain quality. Because workshops were more likely to

be given in areas geographically close to the University of Kentucky than in outlying areas, we recommend that special efforts be made to recruit future volunteers from outlying areas and to publicize their availability to conduct workshops. Finally, we would recommend that administrators not become overly attached to an "unpaid volunteer" model. Because the volunteers are providing a professional service for which individuals ordinarily expect to be paid, we recommend that money from private sources be used whenever possible to compensate volunteers for their time and expertise.

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APPENDICES

THE COURIER-JOURNAL AND THE LOUISVILLE TIMES, MONDAY, JANUARY 21, 1985

CARRY ON

Coordinator wants to awaken talents of retired older people for pilot extension project

Katherine Kirwan
Courier-Journal columnist

LEXINGTON, Ky. — Phyllis Hanna of the University of Kentucky Council on Aging is busy these days sifting through applications.

She has been named coordinator of a pilot project, the Gerontological Extension Program, that aims to link the talents and skills of retired older people with the needs of the state's older population.

If the program is successful, it will serve as a model for communities across the country.

Gerontologists for years have lamented that the skills of too many older men and women lie dormant once they retire. All the expertise, the judgment and the experience acquired through years of work seem to retire with them.

This program aims to utilize the expertise of 36 retirees, selected from applications that will be accepted until Feb. 1.

These 36 volunteers will receive intensive training and then go out in the state to conduct training workshops. These workshops will be open to anyone providing services to the elderly.

Training sessions will be divided into five areas: consumer economics, drugs and medication practices, coping skills and adaptation, nutrition and food preparation, and home health care.

"We have received a good many applications from retired teachers," said Mrs. Hanna. "With their experience and our training in subject matter, they should be very effective."

But she also stressed the importance of background in specialized areas. Retired doctors, nurses and pharmacists, for example, could handle the sessions on drugs and medication practices. Former economics teachers, bank and insurance employees would be natural instructors in consumer economics.

Retired home economics teachers, dietitians and county agents would make ideal leaders in nutrition and food preparation. In the course on coping and adaptation, former ministers, counselors and social workers could make a valuable contribution.

Each volunteer selected will attend six half-day training sessions in one of the designated areas. These sessions will be taught by UK faculty members on the campus in Lexington. They will run on successive Saturdays beginning March 9 and continuing through April 20.

With this preparation, the volunteers will be assigned to one or two training programs a month over a six-month period beginning in May. It is hoped that workshops will be scheduled in at least 45 communities.

Each volunteer will receive a $500 stipend plus expenses to and from training sites. The Gerontology Extension Program is funded in part by a grant from the federal Administration on Aging.

The proposal for the grant was written by Jon Hendricks of the UK sociology department. He cited the increased service load of human service agencies caused by the nationwide growth in the number of older people.

He pointed out that personnel have been placed in positions with little training or with an inability to remain abreast of latest developments. This new program has been designed to meet such shortcomings in personnel.

The courses should be of value to mental health workers, adult day-care centers, nursing home staff members and a variety of paid and volunteer workers in religious, civic and community organizations.

The project co-directors are Hendricks and Linda Brasfield, director of the Council on Aging. The council functions under the UK Multidisciplinary Center of Gerontology.

Community agencies providing services to the elderly should notify the Council on Aging if they are interested in scheduling courses.

Requests for volunteer applications or for the scheduling of workshops should be directed to Mrs. Hanna, UK Council on Aging, Ligon House, Lexington 40506-0442. Or call (606) 257-8138.

Staff Photo by Stewart Bowman

Coordinator Phyllis Hanna talks with Harold Binkley, the first applicant for the Gerontological Extension Program.

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ACCENT

Plan to aid elderly has everything but money

Al Allen
Courier-Journal columnist

"We elderly people have something unique to offer. Not textbook knowledge but living experiences that color life and give it dimension," says Mrs. Joseph Mann.

"So many of those providing services to seniors don't understand the problems of older people they are dealing with — they're too young to appreciate them fully. Something like this is useful," says Irving Lipetz.

"I'd like to see the program continue and so would the others. Most of us would even pay our own expenses," says William S. Stewart.

Mrs. Mann, Lipetz and Stewart are talking about the Gerontology Extension Program, an experiment last year by the University of Kentucky. It aimed to see if people who provide services to the elderly can benefit from seminars taught by retired people.

It has been evident for years that something of the sort was needed. As Dr. Jon A. Hendricks of UK's Sociology Department and principal investigator of the program put it, "At the middle and lower levels of agencies that provide service to the elderly . . . the people who are closest to the clients . . . the lack of knowledge is sometimes appalling."

Trained people command high salaries, and money is scarce. So agencies frequently make do with marginally trained but affordable employees. And, because of a high turnover rate in such positions, on-the-job experience is often lost, or never gained.

But, Hendricks and his colleagues reasoned, what if you recruited a group of experienced retired people, brought them to UK for special training, then sent them out to teach seminars for the people who serve the needy elderly?

Judging from the enthusiasm of almost everyone who took part in the Gerontology Extension Program, it has plug the gap. The question now is: Can the funds be found to continue it?

The program was set up early in 1985 by the UK Council on Aging and the Center for Developmental Change with $100,000 from the federal Administration on Aging and $40,000 in matching funds from UK. It was under the direction of Hendricks and Linda C. Brasfield, director of the UK Council on Aging.

They recruited volunteers throughout the state and early in 1985 about 80 retired Kentuckians went to Lexington, at their own expense, for interviews. From these, 40 — among them Stewart, Lipetz and Mrs. Mann — were selected for training in one of six fields: consumer economics, drugs and medication, coping skills, nutrition and food preparation, and home health care and nursing.

The classes were conducted by UK faculty members during six sessions in March and April. The volunteers received 24 hours of instruction in the areas they selected for specialization and four on how to teach.

Once their training was completed, Hendricks and his colleagues offered the volunteers' services to senior citizen centers, nursing homes, home health care, meal service and other similar social-service programs. Each volunteer got $540, plus expenses, for undergoing the training and conducting up to four workshops.

From April through November, when the program ended, the volunteers conducted 147 workshops in 47 locations. Hendricks' data show that about 20 people attended each workshop, and that his 39 volunteers — one of the original 40 having dropped out — provided information to approximately 3,000 professionals, paraprofessionals, nurses and administrators.

During and after the sessions, Hendricks and his colleagues ran checks on their effectiveness and found it exceptionally high. "Most agencies said they would use volunteers for future presentations if they were available," he says.

The elderly volunteers are equally enthusiastic. Most have told Hendricks they'd like to see the program continued even if they had to pay their own expenses.

Lipetz, of Louisville, a retired Social Security official and president of the Kentucky Association for Older Persons, made talks about drugs and education, emphasizing "the need for better communication between doctor and patient."

Stewart, a retired sales and marketing executive who lives in Shelbyville, Ky., and specialized in consumer economics for the program, agrees. He taught his workshop participants about hidden resources many older people have without realizing it, and raised warning flags about fraud and deceptions practiced on the elderly.

Mrs. Mann of Louisville, a former Jefferson County teacher and school administrator, specialized in methods of coping with death.

"You know," she said, "I've found that many people, even ministers and doctors, are unable to deal with someone who has lost a loved one. They don't know what to say. They don't understand that you don't really have to say anything — just be there . . . listen . . . touch."

Hendricks, Ms. Brasfield and their colleagues asked the state for $18,000 to revive the program for another year. The money would fund a bare-bones program — enough to conduct refresher training for 20 volunteers, half last year's number — and send them out to conduct about 50 programs instead of last year's 147.

However, late last month they were turned down. The Division of Aging Services, he was told, could not undertake to be the program's sole support. How much it could support, Hendricks was not told.

That leaves the private sector, and he's since been knocking on corporate doors for money to finance the program.

After all, he's got 39 trained, eager retirees champing at the bit.

The Prime Time column, written by Al Allen, alternates weekly with one that answers questions of interest to older people and their families. It is written by the Kentucky Association for Older Persons. Readers should address their questions to Prime Time, Accent Department, The Courier-Journal, 525 W. Broadway, Louisville, Ky. 40202.

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UKNEWS
UNIVERSITY OF KENTUCKY
• INFORMATION SERVICES •
Room 4 Mathews Bldg. Lexington 40506-0047

APPENDIX B

March 13, 1986

Final News Release

Barbara Hickey 606-257-1909

TRAINING PROGRAM FOR PERSONS WHO CARE FOR ELDERLY RATED SUCCESSFUL

A series of 1985 statewide workshops in which volunteers tutored persons on how to provide care for the elderly has concluded very successfully, say program participants.

"We were very well tutored at UK by specialists who wanted us to know more," said Brad Will of Lexington, one of 40 retired professionals in the University of Kentucky's gerontology extension program which gave 147 presentations to people who care for elderly persons.

Approximately 3,000 nursing aides, registered nurses, licensed practical nurses and social services personnel employed in nursing homes, hospitals, health services and other types of agencies serving the elderly attended the programs presented during 1985 in all of Kentucky's area development districts.

UK officials hope to find new funds to continue the program.

The workshops were in coping skills and adaptation, consumer economics, drugs and medication practices, home health care and nursing, and nutrition and food preparation.

The trainers received state-of-the-art information from UK faculty before going "on the road," according to Linda Brasfield, director of the UK Center on Aging.

-more-

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Will, a UK graduate and a retired tax consultant who gave workshops in consumer economics to groups in Owensboro, Lexington, Monticello and Prestonsburg, thinks the program is an economical way to instruct agencies providing services to the elderly.

Laurie Pollard who coodinated five workshops for volunteers in the Christian Appalachian Project, an ecumenical service organization that helps Eastern Kentucky people become self-sufficient, says the workshops help her in two ways.

Pollard operates two food pantries in Lincoln and Rockcastle counties and she watches to see that her clients don't get foods with too much salt and she always keeps low-salt items available.

Pollard also visits elderly persons in those two counties and in Garrard County and she watches to see if they are getting the right things to eat, particularly if they have an illness requiring a certain kind of diet.

Lisa Wilcher, a CAP home visitor who provides grocery and medical transportation to people in Rockcastle and nearby counties, also finds the workshops helpful. "They were worthwhile. It's nice having something like that as an added resource. The information given on diabetes was especially helpful," she said.

The program was eminently successful," said Dr. Jon Hendricks, UK professor of sociology and project coordinator.

The program was set up by the UK Council on Aging and the Center for Developmental Change with $100,000 from the federal Administration on Aging and $40,000 in matching funds from UK.

-more-

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"The majority of the retirees who delivered these services expressed not only willingness to give the workshops again but dedication to give them without remuneration, if necessary," Hendricks added.

Administrators of agencies where workshops were given were complimentary, Henricks said. "They said the workshops were educational and enlightening and within their budget limits."

Each workshop cost just over $200 compared with at least $500 to bring in an outside consultant, Hendricks added.

Overall consultation was provided by Marge Brock of the Kentucky Bureau of Human Resources and her training officer, Nancy Cox, Hendricks said. Phyllis Hanna of the Council on Aging was the program coordinator.

The researchers hope to gain new funding to offer the workshops in 1986

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LEXINGTON, KENTUCKY 40506-0442

COUNCIL ON AGING
MULTIDISCIPLINARY CENTER OF GERONTOLOGY
LOGAN HOUSE

APPENDIX C

Informational Announcement

April 3, 1985

Dear Friend:

The University of Kentucky is sponsoring a unique educational program to help get timely information relative to the needs of older persons to service providers and caregivers across the state. Workshops would be appropriate for personnel from senior centers, nutrition sites, nursing homes, home health agencies and other organizations concerned with upgrading their skills and knowledge base in the five subject areas.

A program brochure is enclosed for your information. If you have any questions or would like to sponsor a workshop in your community, please contact me, 606/257-8138, or Ms. Beth Church, 606/257-8301, at the University of Kentucky Council on Aging.

We greatly appreciate your assistance in sharing information with persons who might benefit.

Sincerely,

Phyllis S. Hanna
Program Coordinator

PSH:bc
Enclosure

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University of Kentucky

GERONTOLOGY EXTENSION PROGRAM

1985

Purpose:

The purpose of the project is to utilize the skills and expertise of older volunteers to extend our knowledge in five subject areas to agency personnel across the state. These areas are:

Consumer Economics
Drugs and Medication Practices
Coping Skills and Adaptation
Nutrition and Food Preparation
Home Health Care

Who Can Participate?

Volunteers are sought from many different backgrounds. Criteria include:

* Teaching experience or excellent communication skills.
* Public speaking experience.
* Background or interest in the specific area.
* A major interest in providing service to the community.

What Will Be Required?

Volunteers will attend six half-day training sessions in one of the above subject areas. Sessions will be taught by University of Kentucky faculty and will be held on the campus of the University.

They will then be asked to teach in one or two in-service training programs per month over a six-month period (from May - October, 1985).

Training Dates

Saturday, March 9 - April 20, 1985 (no class April 6)

Benefits to Volunteers

Each volunteer will receive a $500 stipend for the training and travel expenses to and from in-service sites.

The Gerontology Extension Program is funded in part by a grant from the Administration on Aging.

If you would like to apply . . . .

Call or write

Mrs. Phyllis Hanna, University of Kentucky, Council on Aging, Ligon House Lexington, Kentucky, 40506-0442. (606)257-8138.

IN-SERVICE TRAINING WORKSHOPS*
AT YOUR SITE

JUNE - OCTOBER 1985

GERONTOLOGY EXTENSION PROGRAM

A unique training opportunity for service providers

NURSING HOMES
HOME HEALTH AGENCIES
SENIOR CENTERS
MEAL SERVICES
SENIOR CITIZEN APARTMENTS
HEALTH DEPARTMENTS

ANYONE PROVIDING DIRECT SERVICES TO THE ELDERLY

Sponsored by
The University of Kentucky
Council on Aging
and
Center for Developmental Change

TO SCHEDULE WORKSHOPS AT YOUR CONVENIENCE
Call Beth Church, (606) 257-8301
Or 1-800-432-0963 and ask to be transferred to 7-8301

*AoA FUNDED TRAINING OPPORTUNITIES

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Project staff

Jon A. Hendricks, Ph.D., Principal Investigator
Linda C. Brasfield, M.S., Co-Investigator
Phyllis S. Hanna, Coordinator
Thomas R. Ford, Ph.D., Administrative Coordinator
Beth Church, Secretary
Howard Turner, Research Assistant
Ray LaFollette, Special Assistant
James G. Hougland, Ph.D., Program Evaluator

University faculty

Steven R. Adams, R.Ph.
Gloria H. Doughty, R.Ph.
Louise G. Dutt, Ph.D.
Mary Ellen Edmondson, Ph.D.
Raymond E. Forgue, Ph.D.
Abby L. Marlatt, Ph.D.
Michael R. Nichols, Ph.D.
Mary Alice Pratt, R.N., M.Ed.
Betty B. Spohn, Ed.D.
Myrna M. Wesley, M.S.

More about the subject areas

The training workshops are designed to give service providers practical information for use in their day-to-day work with older persons. Our primary goal is to improve services to older citizens of Kentucky. The subject areas are broad and include many possible topics which might be of value to you.

Some of the possible topics include:

Consumer Economics – Frauds and consumer assistance; housing; money management; insurance (life, health, property); social security and other benefits.

Drugs and Medication Practices – Physiologic, economic and social considerations; risk factors; signs of and prevention of drug misuse.

Coping Skills and Adaptation – Methods of coping with retirement; personal loss: illness; changes of environment; death and dying; defense mechanisms; stress management.

Nutrition and Food Preparation – Relation to health and health problems: obesity, constipation, osteoporosis, poor circulation; meal planning; food quackery; community resources.

Home Health Care and Nursing – Prevention of disease; exercise and nutrition; mental health; adjusting to handicaps; community resources.

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GERONTOLOGY EXTENSION PROGRAM

A unique training opportunity for service providers

Sponsored by
The University of Kentucky
Council on Aging
and
Center for Developmental Change

Ever wish you could send your staff to school? Ever wish you could bring outside experts to your in-service programs? Ever wish your training dollars would stretch further?

The GERONTOLOGY EXTENSION PROGRAM will bring The University to you.

Purpose

The project utilizes the skills and expertise of older volunteers and extends knowledge in five priority areas (identified by the Kentucky Division of Aging Services) to agency personnel across the state.

All trainers are retired professionals who have received state-of-the-art information from faculty at The University of Kentucky during the early spring of 1985.

The areas are:

Consumer Economics
Drugs and Medication Practices
Coping Skills and Adaptation
Nutrition and Food Preparation
Home Health Care and Nursing

The **GERONTOLOGY EXTENSION PROGRAM** is funded in part by a grant from the Administration on Aging. It is intended as an effective mechanism to upgrade or augment existing knowledge bases.

Who can benefit?

In-service training workshops are available free of charge to all groups who provide services to older people in the state of Kentucky.

Senior citizens centers, nursing homes, home health care providers, social workers, long-term care ombudsman, and meal service programs are among the many groups who will find the training invaluable.

What will be required?

Workshops may be requested by directors of agencies or organizations who work with senior citizens.

The requesting group is responsible for securing an audience and making all local arrangements regarding meeting rooms and equipment.

Two or more groups in a given locale may also sponsor workshops together.

Training dates

Half-day or day-long workshops will be scheduled from May through October, 1985. Presentations may be requested in two or more of the subject areas depending on the need.

For more information, or to schedule workshops . . . .

Call or write:

Ms. Beth Church
The University of Kentucky
Council on Aging
Ligon House
Lexington, KY 40506-0442
Phone: (606) 257-8301

(Clip and mail)

Workshop Request Form

Requesting Agency _____

_____

Contact Person _____ _____

_____

Address _____

_____ Zip_____

Business Phone (____) _____

I would be interested in training in the following areas:

____ **Consumer Economics**
____ **Drugs and Medication Practices**
____ **Coping Skills and Adaptation**
____ **Nutrition and Food Preparation**
____ **Home Health Care and Nursing**

-69-

Best dates for training for my organization would be (3 weeks notice required):

_____

_____

Personnel to be involved in training (by job title or responsibility):

_____

_____

Estimated number involved: _____

Return to: Beth Church, CoA, Ligon House, UK, Lexington, KY 40506-0442

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UNIVERSITY OF KENTUCKY
LEXINGTON, KENTUCKY 40506-0442

COUNCIL ON AGING
MULTIDISCIPLINARY CENTER OF GERONTOLOGY
LIGON HOUSE

APPENDIX D

Mock Contract

AGREEMENT

_____I agree to attend 6 training sessions at the University of Kentucky on six Saturdays in March and April, 1985.

_____I will conduct one or two workshops each month during the period of May through October 1985.

_____I am willing to travel within the state of Kentucky where workshops may be scheduled. (Travel expenses will be reimbursed at 18¢ a mile; meals and lodging at approved University of Kentucky rates: $3.00 for breakfast, $3.00 for lunch, $8.00 for dinner, $35.00 for rooms.)

Date_____ Signed_____

Please return within five (5) days in the enclosed envelope.

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2/20/85

UNIVERSITY OF KENTUCKY
Gerontology Extension Program

This certificate is awarded to

in recognition of successful completion of

Project Director, Gerontology Extension Program	**Director, Council on Aging**

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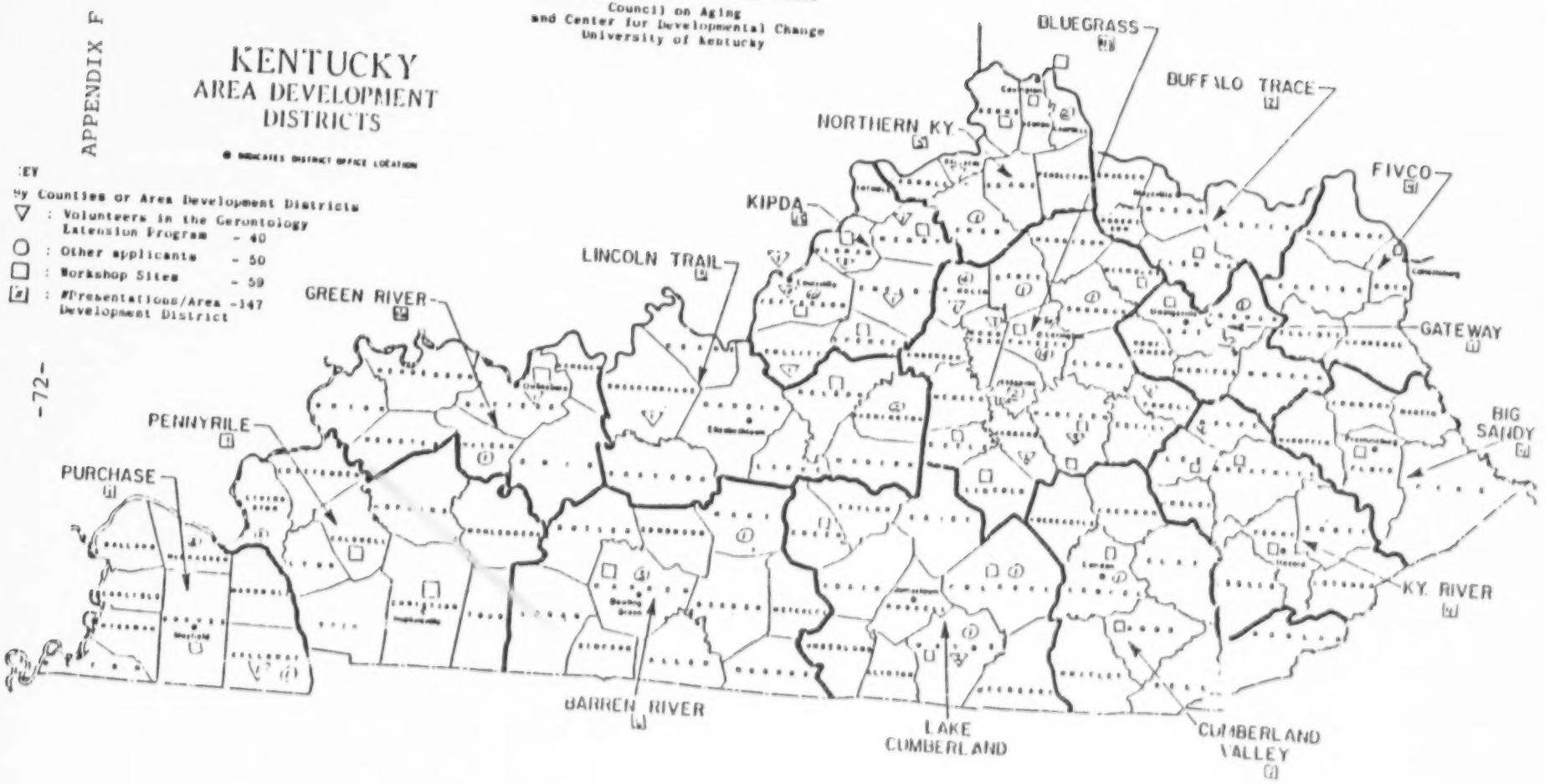
APPENDIX F



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APPENDIX G

Evaluation of Presentation

Gerontology Extension Program

Please give us your comments on the presentation delivered to your group or organization by the volunteer(s) from the Gerontology Extension Program. The following items give you an opportunity to rate several dimensions of the volunteer's presentation. For each dimension, please circle the letter that best represents your view of the quality of the presentation. Letters correspond to a university grading scale, with **A** indicating an **excellent** performance and **E** indicating **failure.** Each dimension is followed by space for brief comments. Please feel free to elaborate on these comments or to introduce additional considerations at the end of the form.

1. The volunteer's command of the subject matter.

A B C D E

Comments:

2. The effectiveness with which the volunteer presented the material and engaged the attention of the audience.

A B C D E

Comments:

3. The appropriateness of the presentation for the specific needs of your organization or group.

A B C D E

Comments:

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4. Please indicate your interest in hearing presentations from other volunteers in the Gerontology Extension Program.

_____ very interested
_____ somewhat interested
_____ not very interested
_____ not at all interested

5. How much training or professional experience have you had in the subject of the volunteer's presentation?

_____ a great deal
_____ some
_____ little
_____ none

It is not necessary for you to write your name or the name of your organization on this form, but please enclose a business card or a slip of paper with information that will allow us to know you have responded.

Please return this form to:

Ms. Phyllis Hanna
Council on Aging
Wilson House
University of Kentucky
Lexington, KY 40506-0042.

Thank you for your cooperation. The space below is for any additional comments you wish to make.

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APPENDIX H

Items Included in Scales

Facts on Aging

The majority of old people (past age 65) are senile (i.e., defective memory, disoriented, or demented).

All five senses tend to decline in old age.*

The majority of old people have no capacity for sexual relations.

Lung vital capacity tends to decline in old age.*

The majority of old people feel miserable most of the time.

Physical strength tends to decline in old age.*

At least one-tenth of the aged are living in long-stay institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.).

Aged drivers have fewer accidents per person than drivers under age 65.*

Most older workers cannot work as effectively as younger workers.

About 80% of the aged say they are healthy enough to carry out their normal activities.*

Most old people are set in their ways and unable to adapt to change.

Old people usually take longer to learn something new.*

It is almost impossible for the majority of old people to learn something new.

The reaction time of older people tends to be slower than the reaction time of younger people.*

In general, older people tend to be pretty much alike.

The majority of old people report that they are seldom bored.*

The majority of older people say they are lonely.

Older workers have fewer accidents than younger workers.*

Over 17% of the U. S. population are now age 65 or older.

The majority of medical practitioners give low priority to older people.*

The majority of old people have incomes below the poverty level.

The majority of old people want to be doing some kind of work (including housework and volunteer work).*

Older people tend to become more religious as they age.

The majority of old people report that they are seldom irritated or angry.*

The health and socioeconomic status of older people (compared to younger people, in the year 2000 will probably be about the same as now.

Possible responses: true or false.

True statements are marked with an asterisk.

Self-Esteem

I feel that I'm a person of worth, at least on an equal plane with others.

I feel that I have a number of good qualities.

All in all, I am inclined to feel that I am a failure.*

I am able to do things as well as most other people.

I feel I do not have much to be proud of.*

I take a positive attitude toward myself.

On the whole, I am satisfied with myself.

I wish I could have more respect for myself.*

I certainly feel useless at times.*

At times I think I am no good at all.*

Possible responses: Strongly agree
Agree
Disagree
Strongly disagree

* indicates scoring reversed.

Morale

Things keep getting worse as I get older. (yes, no)

How much do you feel lonely? (not much, a lot)

Little things bother me more this year. (yes, no)

I see enough of my friends and relatives. (yes, no)

As you get older you are less useful. (yes, no)

I sometimes worry so much that I can't sleep. (yes, no)

I sometimes feel that life isn't worth living. (yes, no)

I am afraid of a lot of things. (yes, no)

I get mad more than I used to. (yes, no)

Life is hard for me most of the time. (yes, no)

How satisfied are you with your life today?
(satisfied, not satisfied)

I take things hard. (yes, no)

I get upset easily. (yes, no)

Underlined responses indicate greater morale.

Lonely Dissatisfaction (Subscale of Morale)

How much do you feel lonely? (not much, a lot)

I sometimes feel that life isn't worth living. (yes, no)

Life is hard for me most of the time. (yes, no)

How satisfied are you with your life today?
(satisfied, not satisfied)

Underlined responses indicate greater morale.

Social Alienation

Almost everything these days is a racket.

These days a person doesn't know who he can count on.

Everybody takes advantage of older people.

It's hardly fair to bring children into the world with the way things look for the future.

Young people don't realize that old people have problems.

Possible responses: Agree
Can't say
Disagree

Agreement with each statement indicates a high degree of social alienation.

Perceptions of Health

According to the doctors I've seen, my health is now excellent.

I try to avoid letting illness interfere with my life.

I seem to get sick a little easier than other people.*

I feel better now than I ever have before.

I will probably be sick a lot in the future.*

Most people get sick a little easier than I do.

I am somewhat ill.*

In the future, I expect to have better health than other people I know.

I was so sick once I thought I might die.*

I'm not as healthy now as I used to be.*

I worry about my health more than other people worry about their health.*

My body seems to resist illness very well.

I'm as healthy as anybody I know.

I think my health will be worse in the future than it is now.*

I've never had an illness that lasted a long period of time.

Others seem more concerned about their health than I am about mine.

My health is excellent.

I expect to have a very healthy life.

I accept that sometimes I'm just going to be sick.*

I have never been seriously ill.

When there is something going around, I usually catch it.*

I feel about as good now as I ever have.

Possible responses: Definitely true
Mostly true
Don't know
Mostly false
Definitely false

* indicates scoring reversed.

Current Health (subscale of Perceptions of Health)

According to the doctors I've seen, my health is now excellent.

I feel better now than I ever have before.

I am somewhat ill.*

I'm not as healthy now as I used to be.*

I'm as healthy as anybody I know.

My health is excellent.

I feel about as good now as I ever have.

Possible responses: Definitely true
Mostly true
Don't know
Mostly false
Definitely false

* indicates scoring reversed.

Prior Health (subscale of Perceptions of Health)

I was so sick once I thought I might die.*

I've never had an illness that lasted a long period of time.

I have never been seriously ill.

Possible responses: Definitely true
Mostly true
Don't know
Mostly false
Definitely false

* indicates scoring reversed.